CHI St. Alexius Health
Imagine better health.℠

Employee Assistance Program
900 East Broadway
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Bismarck, ND 58506-5510

P 701.530.7195
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Toll Free 800.327.7195
CHIStAlexiusHealth.org

ASSESSMENT/CLIENT INFORMATION

Affiliate Instructions: Complete (print clearly), sign and return this form along with the signed Statement of Understanding and Notice of Privacy Practices along with the first session Affiliate Reimbursement Form. Fax: 701-530-7193 care of M. Liberda or mail to CHI St. Alexius Health EAP, 1310 East Main Avenue, PO Box 5510, Bismarck, ND 58506-5510.

You are being asked to provide information which we believe is critical to your care. By completing the form, we will be better able to attend to your issues in the sessions. If you believe that an item does not apply or is confusing, please feel free to proceed to another item and discuss with your EAP counselor. **All information provided remains strictly confidential.**

Client Name: | Date of Birth:

Address:

City: | State: | Zip:

Gender
☐ Male
☐ Female

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Home Telephone Number _____ May we contact you at this number Y ☐ N ☐
Cell/Mobile Phone _____ May we contact you at this number Y ☐ N ☐
Work Telephone Number _____ May we contact you at this number Y ☐ N ☐

Who referred you to EAP?
☐ Self
☐ Family Member
☐ Supervisor Job Performance
☐ Supervisor Personal Concern
☐ Other Employees
☐ Human Resources
☐ Friend
☐ Other

OTHER FAMILY MEMBERS IN YOUR HOUSEHOLD

Name	Date of Birth	Relationship

INFORMATION ABOUT EMPLOYEE WHO HAS EAP BENEFIT

The person using the EAP is:
☐ Employee ☐ Employee's Spouse ☐ Employee's Child ☐ Another Relative ☐ Other

Name of Employee | Date of Birth | Gender ☐ Male ☐ Female

Name of Employer or Organization which provides the EAP benefit. | Year employee Started _____

Does client supervise other employees? ☐ Yes ☐ No

Employee' Occupation is:
☐ Professional
☐ Admin/Mgmt.
☐ Technician
☐ Sales
☐ Laborer
☐ Skilled Craft
☐ Clerical
☐ Operative/Maintenance

How serious is this problem for you?	Not Very Serious ☐	Somewhat Serious ☐	Very Serious ☐
How has this affected your:	Not At All	Somewhat	Very Much
Marriage/Partner	☐	☐	☐
Family	☐	☐	☐
Job/School Performance	☐	☐	☐
Friendships	☐	☐	☐
Financial Situation	☐	☐	☐
Legal Situation	☐	☐	☐
Health	☐	☐	☐
Anxiety Level	☐	☐	☐
Mood	☐	☐	☐
Eating Habits	☐	☐	☐
Sleeping Habits	☐	☐	☐
Ability to Control Your Temper	☐	☐	☐
Spirituality	☐	☐	☐

Briefly describe your concern:

About how long has this been a concern for you?

Are you currently on any Medications? (Please Specify)